

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH:

County Worcester CoCity or town Berlin Md Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME

Edward J Brudell

3. (b) Social Security Number

no

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Edna J Brudell

7. Birth date of

deceased (mo., day, yr.)

about 1873

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Worcester Co Md

(Town, county, and state)

10. Usual occupation

applicant

11. Industry or business

Lawson Mill Farm

FATHER

12. Name

Edward Brudell

13. Birthplace

Worcester Co Md

MOTHER

14. Maiden name

Hester Challinor

15. Birthplace

Berlin Md

16. Informant

Norm Lizzie Ayers

Address

Berlin Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

near Berlin Md

Location

Berlin Md

18. Funeral director

James H Stewart

Address

Salisbury Md

19.

(Date rec'd by registrar)

19

4-7-48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1948 at 8:30 M21. I CERTIFY that death occurred on the date above stated; that I deceased deceased fromApril 3rd 1948 to 1948and that I last saw h..... alive on 2nd day 19

Immediate cause of death

Unknown

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address near Berlin Md Date signed 4/3/48

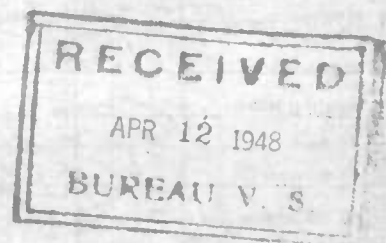
MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04330 355

1. PLACE OF DEATH:

County Worcester
City or town Whaleysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ind County Worcester
City or town Whaleysville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

John William Budinger

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Edith L. Budinger

7. Birth date of deceased (mo., day, yr.)

Feb 10 - 1889

6. (c) If alive, give age

25 years

8. AGE:

Years 59 Months 2 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace

Germany
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Budinger

13. Birthplace

Germany

MOTHER

14. Maiden name

unknown

15. Birthplace

Germany

16. Informant

Mr. Edith L. Budinger

Address

Whaleysville Ind.

17.

(Burial, cremation, or removal? Which?) Date thereof April 28 - 48
(month) (day) (year)

Cemetery or crematory

Salisbury Ind.

Location

Holloway & G. Walter R. Holloway

18. Funeral director

Salisbury Ind.

Address

19.

4-28-48 Helen S. Hayward

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25th 1948 at 6:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1948 to 25th Apr 1948 and that I last saw him alive on 25th Apr 1948

Immediate cause of death

acute coronary thrombosis

DURATION

15 min

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Injured at work?

23. SIGNATURE

H. S. Hayward M.D.

M. D. or other

Address

Berlin, Ind.

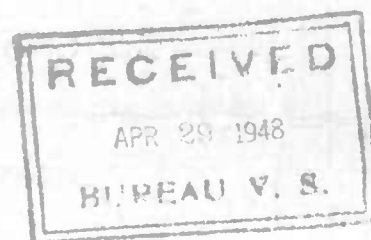
Date signed 26th Apr 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

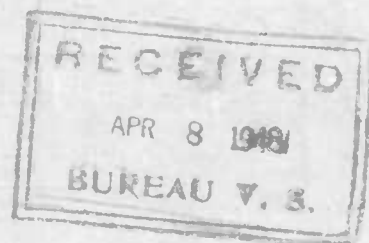
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH: County..... <u>Worcester</u> City or town..... <u>Pocomoke City</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>80 years</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Worcester</u> City or town..... <u>Pocomoke City</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>101 4th Street</u> (If rural, give LOCATION) 2(a) If veteran, name war.....			
3. (a) FULL NAME <u>Van Delia Dryden</u>				3. (b) Social Security Number			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>Joshua Donohoe</u>				20. DATE OF DEATH <u>April 4</u> 19 <u>48</u> at <u>9:30 A.M.</u>			
7. Birth date of deceased (mo., day, yr.) <u>June 9, 1858</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>April 3</u> 19 <u>48</u> to <u>April 4</u> 19 <u>48</u>			
8. AGE: Years <u>89</u> Months <u>9</u> Days <u>25</u> If less than one day hrs. min.				and that I last saw him alive on <u>April 3</u> 19 <u>48</u>			
9. Birthplace <u>Quantico, Wicomico, Md.</u> (Town, county, and state)				Immediate cause of death <u>Myocardial Infarction</u>			
10. Usual occupation <u>House wife</u>				Other conditions (Include pregnancy within 8 months of death)			
11. Industry or business				Major findings of operations Date of op.			
FATHER		12. Name <u>Andrew Crawford</u>		Autopsy results		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
13. Birthplace <u>Wicomico County</u>		14. Maiden name <u>Mary A. Twilley</u>		22. VIOLENCE: If death was due to external causes, fill in the following:		Accident, suicide, or homicide Date of	
MOTHER		15. Birthplace <u>Quantico, Md.</u>		Where did injury occur? (City or town) (County) (State)		Injured at home, farm, industry, public place (where?)	
16. Informant <u>Lacey Dryden</u>		Address <u>Walnut St., Pocomoke City, Md.</u>		Means of Injury		Injured at work?	
17. (Burial, cremation, or removal, Which?) <u>Burial</u>		Date thereof <u>April 6, 1948</u> (month) (day) (year)		23. SIGNATURE <u>C. E. Ditcher</u>		M. D. or other	
Cemetery or crematory <u>St. Mary's Episcopal Cem.</u>		Location <u>Second St. Pocomoke, Md.</u>		Address <u>Worcester</u>		Date signed <u>April 6, 48</u>	
18. Funeral director <u>H. Harrison Bradshaw</u>		Address <u>Pocomoke City, Md.</u>		19. (Date rec'd by registrar) <u>April 6, 1948</u>		Registrar <u>Anne E. White</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04332
355

1. PLACE OF DEATH:

County Worcester
 City or town Whaleyville Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Worcester
 City or town Whaleyville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rural
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Horace Fooks

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife Florence Bailey

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb 23, 1893

8. AGE: Years 75 Months 1 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Whaleyville Worcester Co Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Joseph Fooks

13. Birthplace Md.

14. Maiden name Elizabeth Ellis

15. Birthplace Md.

16. Informant William Fooks

Address 90 Church St N. Y. City

17. Burial Date thereof April 13, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fassett

Location near St. Martin's Md.

18. Funeral director M. Rasha Watson

Address Shelburne, Vt.

4-18-48

19. Helen E. Hayward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16-1948 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____
April 4th, 1948 to _____
when saw him alive and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____ DURATION _____

Natural Causes

Due to (Probably Coronary occlusion)

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

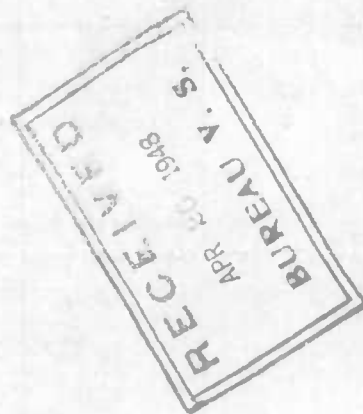
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. E. Johnston, M.D.

Address Rock Hill, Md. Date signed 4/14/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04333

Reg. Diat. No.

355

1. PLACE OF DEATH:

County Worcester
 City or town Worcester
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey County Cape May
 City or town Wildwood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 346 W. Andrews Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

THEODORE HANSEN

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Sigrid Nelson
 6.(c) It alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) 23 June 1885
 8. AGE: Years 62 Months 10 Days 7 If less than one day hrs. min.

9. Birthplace Norway
 (Town, county, and state)
 10. Usual occupation Fahermat
 11. Industry or business

MOTHER FATHER
 12. Name Theodore Hansen
 13. Birthplace Norway
 14. Maiden name No Info
 15. Birthplace Norway
 16. Informant Mrs. Sigrid Hansen
 Address Wildwood, N.J.
 17. Burial (Burial, cremation, or removal. Which?) May 7, 1948
 Cemetery or crematory Presbyterian Cem
 Location Cold Spring, N.J.
 18. Funeral director David D. Blumberg
 Address Berlin, Md.

19. S-2- 48 Helen F. Hayward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30th 1948 at 11 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/1/48 to 5/1/48
 and that I last saw him 5/1/48

Immediate cause of death Drowning
(Accidental)

Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

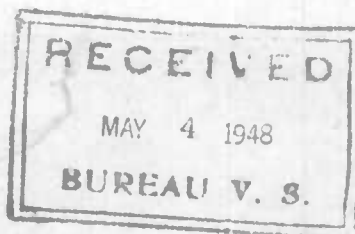
Major findings of operations.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE H. E. Astor
 Address Pocomoke City, Md. Date signed 5/1/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04334

Reg. Dist. No. 354

1. PLACE OF DEATH:

County Worcester
City or town Rural Stockton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Rural Stockton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

John W. Holland

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

8. (b) Name of husband or wife Laura A. Holland

8. (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Oct 12 - 1859

8. AGE: Years 88 Months 6 Days 6 If less than one day hrs. min.

9. Birthplace Rural Pocomoke Worcester, Md.
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

12. Name Peter Holland

13. Birthplace Md.

14. Maiden name Unknown

15. Birthplace

16. Informant Mr Raymond Holland

Address Rural Stockton Md.

17. Burial Date thereof April 21, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Woodwill Mc. Cemetery

Location Rural Pocomoke Md.

18. Funeral director Henry H. Davidson

Address Pocomoke Md.

19. Apr. 21 19 48 May M. Taylor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1948 at 2 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1948 to April 18, 1948
and that I last saw him alive on April 17, 1948

Immediate cause of death Acute Pulmonary Edema

Due to Hypertensive Cardiovascular

Due to Renal disease

Other conditions decubitus ulcers

Hypospadias Pneumonia
(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert L. La Mar, M.D.

Address Enan Md. Date signed 4-20-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH: *Worcester*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... *2 1/2 years*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... *Maryland* County..... *Worcester*
 City or town..... *Snow Hill*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2(a) If veteran, name war..... *70*

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace: (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *April 13*..... 19..... *48*..... at..... *4:30*..... P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 1946*..... 19..... to..... *4/13/48*..... 19..... and that I last saw him alive on..... *7/12/48*..... 19.....Immediate cause of death..... *Infarct type Sclerosis*..... DURATION..... *5 yr*.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

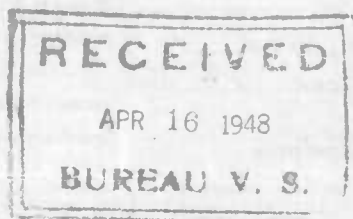
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... *Paul Chen M.D.*Address..... *Snow Hill Md*..... Date signed..... *7/13/48*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04336 355

1. PLACE OF DEATH:

County WorcesterCity or town Ocean City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

JOHN MOORE MUMFORD

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

ELLA K. MUMFORD

7. Birth date of deceased (mo., day, yr.)

AUG. 6, 18826. (c) If alive, give age 65 years

8. AGE:

Years

Months

Days

If less than one day

6583

hrs.

min.

9. Birthplace

Shoreville, Md.
(Town, county, and state)

10. Usual occupation

City official

11. Industry or business

FATHER

12. Name

John Wesley Mumford
Wash.

13. Birthplace

MOTHER

14. Maiden name

Kate Moore

15. Birthplace

Wash.

16. Informant

Address

Mrs. Irma Krug
Ocean City, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Burial
Evergreen

Location

Berlin, Md.

18. Funeral director

Address

Burns A. Burbage
Berlin, Md.

19.

(Date rec'd by registrar)

4-12-48
Helen F. Hayward
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

APRIL 9

19

yr.

at

7:55 P.

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 9

19

yr.

at

April 9

19

yr.

at

48

and that I last saw him alive on

April 9

19

yr.

at

48

yr.

at

48

Immediate cause of death

Coronary Thrombosis

DURATION

April 9.

Due to

Coronary Heart Disease5 years

Due to

Arteriosclerotic Cardiovascular DiseaseIndefinite

Other conditions

—

(Include pregnancy within 3 months of death)

Major findings of operations

—

Date of op.

Autopsy results

—

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. J. Jannard, Jr. M.D.

M. D. or other

Address

Ocean City, Md.

Date signed

April 12, 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 14 1948
BUREAU V. S.

RECEIVED
APR 16 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

04337

CERTIFICATE OF DEATH

Reg. Dist. No. 354

1. PLACE OF DEATH: Worcester
 County Stocketon
 City or town Stocketon
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 57 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Stocketon
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war 70

3. (a) FULL NAME Elizabeth C. Parsons

3. (b) Social Security Number
218-05-9123

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Elmer F. Parsons
 7. Birth date of deceased (mo., day, yr.) June 16 - 1890 8. (c) If alive, give age _____ years

8. AGE: Years 57 Months 9 Days 22 hrs. _____ min.

9. Birthplace Stocketon Worcester Md
 (town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Leahann C. Paulsams

13. Birthplace Maryland

14. Maiden name May J. Brown

15. Birthplace Maryland

16. Informant M. C. Lloyd C. Parsons

Address Stocketon, Md

17. Burial Date thereof April 19/48
 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematorium Brooks Chapel

Location Stocketon, Md

18. Funeral director May C. Dymmis

Address Snow Hill, Md

19. Apr 10 19 48 Mary C. Taylor
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 19 48 at 7:45 PM

21. CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 47 to April 8 19 48
 and that I last saw him alive on April 8 19 48

Immediate cause of death Cancer of breast
recurrent with
metastases to pleura
pelvis spine & brain
 Due to _____
 Due to _____

DURATION
4 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul Owen M.D
Snow Hill M. D. or other _____

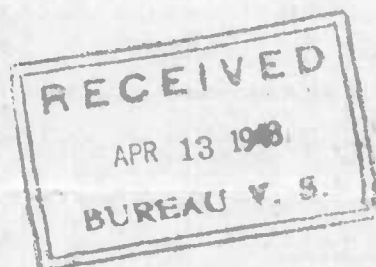
Address _____ Date signed 4/8/48

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 93d 04338 955

1. PLACE OF DEATH:

County WorcesterCity or town Berlin R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 54 years

3. (a) FULL NAME

Emory Bell Luiten

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Lillie I. Luiten

7. Birth date of

deceased (mo., day, yr.)

Jan. 10, 1894 (3)

8. AGE:

Years 55 Months 3 Days 19 If less than one day

9. Birthplace

Berlin Wor. Co. Md.

10. Usual occupation

Mechanics

11. Industry or business

12. Name Charles Luiten

13. Birthplace

Maryland

14. Maiden name

Ellen Jones

15. Birthplace

Maryland16. Informant Mrs. Emory LuitenAddress Berlin Md R.F.D.17. Burial
(Burial, cremation, or removal. Which?)Date thereof 5/2/48
(month) (day) (year)

Cemetery or crematory

Taylorville Churchyard

Location

Berlin Md R.F.D.

18. Funeral director

Anna R. Burbay

Address

Berlin Md.19. 5-2-

(Date rec'd by registrar)

19 48Helen F. Hayward

registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WorcesterCity or town Berlin R.F.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

216-09-5877

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 19 48 at 930 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 16 19 48 to April 29 19 48and that I last saw him alive on April 29 19 48Immediate cause of death Coronary Thrombosis

DURATION

5 wks.Due to Hypertensive C.V.D.5 yrsDue to Pneumonic Heart Disease30 yrs

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE _____

Address Ocean City, Md.

M. D. or other

Date signed Apr 30, 48

RECEIVED

MAY 4 1948

BUREAU V. S.

RECEIVED

MAY 4 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
 City or town Welbourne
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Lifetime
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

PAUL ROBERTS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
 City or town Welbourne
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

February 12, 1897

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

51

1

25

hrs.

min.

9. Birthplace

Welbourne-Worcester-Maryland
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

John Roberts

13. Birthplace

Welbourne, Maryland

14. Maiden name

Elizabeth Broughton

15. Birthplace

Stockton, Maryland

16. Informant

Essie Mills

Address

Welbourne, Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof April 10, 1948
(month) (day) (year)

Cemetery or crematory

Wardtown Cemetery

Location

Md-Va Line, Pocomoke Rt. #3

18. Funeral director

H. Harvey Bradshaw

Address

Pocomoke City, Maryland

19.

April 12, 1948
(Day) (Month) (Year)Anne E. White
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 7, 1948 at 12:21 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

31 March 1948 to 7 April 1948

and that I last saw him alive on

6 April 1948

Immediate cause of death

Cerebral embolus

DURATION

Due to

Chronic myocarditis

Due to

Generalized marked arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

N. E. Sartorius Jr.

M. D. or other

Address

Pocomoke, Md.

Date signed

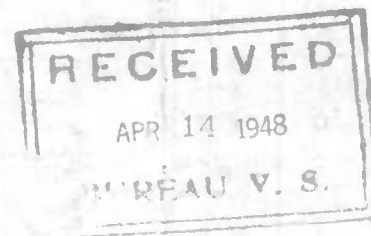
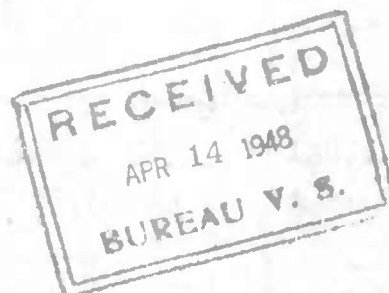
12 April 1948

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04340

Reg. Dist. No. 357

1. PLACE OF DEATH:

County WorcesterCity or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George A. Smack4. Sex Male 5. Color or race White 6.(c) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Mary C. Smack7. Birth date of deceased (mo., day, yr.) Oct. 6 - 18646.(c) If alive, give age 72 years8. AGE: Years 83 Months 6 Days 17 hrs. _____ min. _____9. Birthplace Worcester, Md
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Edgar Smack13. Birthplace Maryland14. Maiden name Hanna Hudson15. Birthplace Maryland16. Informant Melvin E. SmackAddress Snow Hill, Md17. Burial (burial, cremation, or removal) Which? _____ Date thereof April 29/48
(month) (day) (year)Cemetery or crematory WhitcombLocation Snow Hill, Md18. Funeral director Elmer E. SmithAddress Snow Hill, Md19. 4/24/48 (Date rec'd by registrar)Registrar Edgar Smith

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 19 48 at 8:15 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15 19 47 to April 23 19 48and that I last saw him alive on April 22 19 48Immediate cause of death Acute Pulmonary EdemaDURATION 2 daysDue to Hypertensive CardiomegalyRenal disease 10 yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert L. Lamar, MDAddress Snow HillDate signed 4-24-48

RECEIVED

APR 26 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **865 350**

1. PLACE OF DEATH:

County **Worcester**
City or town **Pocomoke**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death **Lifetime**
Hospital, institution, or street address where death occurred:
513 Young St
How long in hospital or institution? *********

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother) **Worcester**
State **Maryland** County **Somerset**
City or town **Pocomoke**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **513 Young St.**
(If rural, give LOCATION)
2.(a) If veteran, name war *********

3. (a) FULL NAME

Larry Lorenzo Tull

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **Colored** 6.(a) Single, married, widowed, or divorced **Single**

6.(b) Name of husband or wife ********* 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) **August 16, 1946**
8. AGE: Years **1** Months **8** Days **28** If less than one day
..... hrs. min.

9. Birthplace **Pocomoke-Worcester-Md.**
(Town, county, and state)

10. Usual occupation **None**

11. Industry or business **None**

12. Name **Harry Sturgis**

13. Birthplace **Pocomoke, Md.**

14. Maiden name **Annie Marie Tull**

15. Birthplace **Pocomoke, Md.**

16. Informant **Annie Marie Tull**

Address **Pocomoke, Md.**

17. Burial Date thereof **Apr 16, 1948**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **St. James Cemetery**

Location **Pocomoke, Md.**

18. Funeral director **H. Harvey Bradshaw**

Address **Crisfield, Md.**

19. **April 15** 19**48** **Janice E. Spires**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **April 14** 19**48** at **7:15 A** M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
..... 19..... to..... 19.....
and that I last saw h..... alive on..... 19.....

Immediate cause of death **Acute intestinal
autosection**

DUE TO.....

DUE TO.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Harry M. Parkford**

M. D. or other **Princesson**

Address..... Date signed **4/15/48**

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

